DEPARTMENT OF HEALTH SERVICES
P.O.BOX 942732
SACRAMENTO, CA 94234-7320
(916) 323-1945

Dear Provider:

Enclosed is the Medi-Cal Supplemental application you requested. Requests for additional applications should be directed to Electronic Data Systems Corporation (EDS), the Medi-Cal fiscal intermediary, at (800) 541-5555.

Instructions for completion of this application are included on the form. Please read the instructions carefully including the reportable reasons that require a Supplemental application. If you are reporting a change of ownership of 50 percent or more, you must complete a new application package. If after reading the instructions you have questions regarding the completion of the application, you may call the Provider Enrollment Branch at (916) 323-1945 between the hours of 8 a.m. and 5 p.m. Applications that are incomplete or not on Department of Health Services (Department) issued forms will be returned to you.

Pursuant to Section 51000.40 of the California Code of Regulations, all changes must be reported to the Department within 35 days of such change.

For more information on the forms and the regulatory requirements for participation in the Medi-Cal program, please visit our website at www.Medi-Cal.ca.gov and click on Publications, then Provider Enrollment.

This Supplemental application does not apply to institutional providers. Please call (916) 255-6199 for instructions if you are an institutional provider and have changes to request.

If you have any questions, please call our office at (916) 323-1945.

Provider Enrollment Branch
Payment Systems Division

Enclosures

MEDI-CAL SUPPLEMENTAL APPLICATION

FOR STATE USE ONLY

Important:

- Read *all* instructions before completing the application.
- Type or print clearly, in ink.
- If you must make corrections, please line through, date, and initial in ink.
- Return completed forms to: Department of Health Services
  Provider Master File Unit
  P.O. Box 942732
  Sacramento, CA 94234-7320
  (916) 323-1945

Medi-Cal provider number	Date

PROVIDER TYPE

- ❒ DME
- ❒ Laboratory
- ❒ Orthotic and prosthetic
- ❒ Pharmacy
- ❒ Physician
- ❒ Provider group
- ❒ Transportation
- ❒ Other provider type (please describe)_____

ACTION REQUESTED

Add:

- ❒ Business activity
- ❒ Clinical Laboratory Improvement Amendment (CLIA)
- ❒ Doing-Business-As (DBA) name
- ❒ Licenses, permits, certificates, etc.
- ❒ Medical transportation vehicle, driver or pilot
- ❒ Seller's Permit
- ❒ Tax Identification number
- ❒ Medicare billing number

Delete:

- ❒ Clinical Laboratory Improvement Amendment (CLIA)
- ❒ Rendering provider
- ❒ Medical transportation vehicle, driver or pilot

Change:

- ❒ Address and/or phone (see instructions for restrictions on a business address change)
- ❒ Medical transportation vehicle, driver or pilot
- ❒ Ownership or control interest less than 50 percent
- ❒ Pharmacist-in-charge
- ❒ Tax Identification number

Miscellaneous:

- ❒ Deactivate provider number
- ❒ Provider Identification Number (PIN)
  - ❒ Issuance (new PIN)
  - ❒ Confirmation (existing PIN)

Complete only the boxes specific to the action requested. Complete boxes 34–39. Complete box 40, if applicable.

General Information

1. Current legal provider name (as listed with the IRS)

2. Business name, if different	3. Business telephone number
	( )

Is this a fictitious business name? ❒ Yes ❒ No	If yes, list the Fictitious Business Name Statement/Permit number	Effective date
	(Attach a legible copy of the recorded/stamped Fictitious Business Name Statement or Fictitious Name Permit, if applicable.)	

4. Business address (number, street)	City	County	State	Nine-digit ZIP code

5. "Pay to" address (number, street, P.O. Box number)	City	State	Nine-digit ZIP code

6. Mailing address (number, street, P.O. Box number)	City	State	Nine-digit ZIP code

7. Federal Employer Identification Number (FEIN) (Attach a legible copy of the IRS form.)	8. Social security number or Individual Taxpayer Identification Number (ITIN) (If Sole Proprietor not using a FEIN, you must disclose this number and attach a legible copy of the ITIN verification, if applicable.) (See Privacy Statement on page 6.)	***FOR STATE USE ONLY***
___ ___ — ___ ___ ___ ___ ___ ___ ___	___ ___ ___ — ___ ___ — ___ ___ ___ ___	
9. Clinical Laboratory Improvement Amendment (CLIA) certificate number (attach a legible copy)	10. State Laboratory License/Registration number (attach a legible copy)	

11. Medicare billing number	12. Seller's Permit number (attach a legible copy)	13. License or certificate number (attach a legible copy(ies))

14. Change to Ownership Information

Entity Type

❒ Sole proprietor ❒ Partnership ❒ Corporation

❒ Limited liability corporation ❒ Government ❒ Other (describe) _____

Name	Title	Ownership percentage

Are you deleting owners? If so, please provide the following information

Name	Title	Ownership percentage

15. Rendering provider to be deleted from the group (attach additional sheets as necessary)

Name	Provider number	Medicare number	Effective date of deletion

FOR DURABLE MEDICAL EQUIPMENT PROVIDERS ONLY

FOR STATE USE ONLY

16. Do you have a retail business open and available to the general public which meets all local laws and ordinances regarding business licensing and operations and is readily identifiable as a place in which you sell, rent, or lease durable medical equipment, incontinence medical supplies, and/or medical supply items? ❒ Yes ❒ No

If no, please explain: _____

_____

Are your equipment and/or supplies:

❒ A. In stock on the premises, or

❒ B. In a warehouse under the applicant's or provider's direct control.

Business days and hours of operation:

Days: _____ Hours: _____

If B is checked, provide the following information for the warehouse:

Address (number, street)	City	State	ZIP code

Who holds an ownership interest in the warehouse? (Use additional sheets if necessary.)

Name		Telephone number ( )	
Address (number, street)	City	State	ZIP code

17. **Change in Business Activities**

Add (please describe)_____

If you are adding a business activity which requires a Bureau of Home Furnishings License, Board of Pharmacy license, or any other type of license, certificate, permit, etc., please list the information here and attach a legible copy of the license to this application:

Bureau of Home Furnishings license (see instructions):

Furniture and Bedding or Furniture Retailer License number (attach a legible copy): _____ Registry number: _____
(If you are a DME provider and are renting beds, your license must bear a Registry number.)

Issuance date: _____ Expiration date: _____

Board of Pharmacy License (see instructions):

Medical Device Retailer license number (attach a legible copy):_____

Issuance date: _____ Expiration date: _____

Medical Device Retailer Exemptee license number (attach a legible copy) _____

Issuance date: _____ Expiration date: _____

Other License, Certificate, Permit, etc.: _____

❒ Delete incontinence medical supplies

FOR MEDICAL TRANSPORTATION ONLY

FOR STATE USE ONLY

18. Vehicle or air ambulance information (attach copy(ies) of certificate(s)) (see instructions)

Air Ambulance (Attach separate sheet if necessary.)

Name	FAA Certificate number		
Address (number, street)	City	State	ZIP code
Name	FAA Certificate number		
Address (number, street)	City	State	ZIP code

Ambulance (Attach separate sheet if necessary.)

CHP Certificate number	Issue Date	Vehicle Identification Number(s)	Make and Model of Vehicle	Year	License

Litter and/or Wheelchair Vans (Attach separate sheet if necessary.)

Vehicle Identification Number(s)	Make and Model of Vehicle	Year	License Number

19. Hours of operation

The business days and hours of operation are:

Days: _____

Hours: _____

20. Geographic area(s) served (list city/county—attach copy of permit)

_____ _____

_____ _____

_____ _____

_____ _____

21. Driver or Pilot Information (attach a legible copy(ies) of driver's license(s) and DMV DL-51(s)) (see instructions)

Driver's Name(s)	Driver's License Number	Year of Expiration	DMV DL-51 *(Driver's Only)*	
			Effective Date	Expiration Date

Pilot's Name(s)	Pilot's License Number	Year of Expiration

Ensure legible copies of the following documents are attached to the application (as applicable):

- ❒ CHP Certificate(s)
- ❒ DMV commercial vehicle registration
- ❒ Proof of full coverage commercial insurance for each vehicle (Vehicle identification number ***MUST*** be listed on policy.)
- ❒ Brake and lamp certificate
- ❒ FAA Certificate
- ❒ DMV DL-51 form signed by a physician for each driver
- ❒ FAA Pilot's License for each pilot
- ❒ California driver's license for each driver
- ❒ Certificates for first aid and CPR for each driver
- ❒ Standard pre-employment drug and alcohol tests lab results for each driver
- ❒ DMV driving history printout for each driver

FOR PHARMACIES ONLY

FOR STATE USE ONLY

NEW PHARMACIST-IN-CHARGE (PIC)

22. Printed name (last) (first) (middle)

23. PIC social security number (***Optional***—Privacy Statement on page 6.)

___ ___ ___ — ___ ___ — ___ ___ ___ ___

24. PIC license number (Attach a legible copy of license and renewal, if applicable.)

25. Driver's license or state-issued identification card number (attach a copy)

State of issuance

If you answer yes to questions 26–31, give details in number 32 (see instructions)

	Yes	No
26. Has the PIC's individual license, certificate, or other approval to provide health care ever been suspended or revoked?	❒	❒
27. Has the PIC's individual license, certificate, or other approval to provide health care ever been lost or surrendered?	❒	❒
28. Does the PIC have an ownership or control interest in any other medical or Medi-Cal health care provider?	❒	❒
29. Has the PIC previously participated in the Medi-Cal program?	❒	❒
30. Has the PIC ever participated in another state's Medicaid program?	❒	❒
31. Has the PIC ever been suspended from a Medicare or Medicaid program?	❒	❒

32. Details for questions 26–31 (see instructions)

33. Do you have a retail business open and available to the general public which meets all local laws and ordinances regarding business licensing and operations and is readily identifiable as a place in which the applicant or provider engages in sales of items? ❒ Yes ❒ No

If no, please explain:

Are your equipment and/or supplies:

❒ A. In stock on the premises, or

❒ B. In a warehouse under the applicant's or provider's direct control.

Business days and hours of operation: Days: Hours:

If B is checked, provide the following information for the warehouse:

Address (number, street)	City	State	ZIP code

Who holds an ownership interest in the warehouse? (Attach additional sheets if necessary.)

Name		Telephone number ( )	
Address (number, street)	City	State	ZIP code

Information About Individual Signing This Application

FOR STATE USE ONLY

34. Printed name of individual signing this application (last) (first) (middle)

35. Gender

❒ Male ❒ Female

36. Driver's license or state-issued identification number and state of issuance (attach a legible copy)

37. Date of birth

38. Social security number (***Optional***—see Privacy Statement below.)

____ ____ ____ – ____ ____ – ____ ____ ____ ____

39. **I declare under penalty of perjury under the laws of the State of California that the foregoing information in this document, in the attachments, the disclosure statement, and provider agreement are true, accurate, and complete to the best of my knowledge and belief. I declare that I have the authority to legally bind the applicant or provider.**

Signature of the person authorized to bind the applicant or provider	Title

Executed at: _____, _____ on _____
(City) (State) (Date)

40. Notary Public—Please see number 40 in the instructions for who must notarize.

Privacy Statement
(Civil Code Section 1798 et seq.)

All information requested on the application, the disclosure statement, and the provider agreement is mandatory with the exception of the social security number for any person other than the person or entity for whom an IRS Form 1099 must be provided by the Department pursuant to 26 USC 6041. This information is required by the Department of Health Services, Payment Systems Division, by the authority of Welfare and Institutions Code Section 14043.2(a) and Title 22, California Code of Regulations, Section 51536. The consequences of not supplying the mandatory information requested are denial of enrollment as a Medi-Cal provider and issuance of the Medi-Cal provider number or denial of continued enrollment as a provider and deactivation of all Medi-Cal provider numbers used by the provider to obtain reimbursement from the Medi-Cal program. The consequence of not supplying the voluntary social security number information requested is delay in the application process while other documentation is used to verify the information supplied. Any information provided will be used to verify eligibility to participate as a provider in the Medi-Cal program. Any information may also be provided to the State Controller's Office, the California Department of Justice, the Department of Consumer Affairs, the Department of Corporations, or other state or local agencies as appropriate, fiscal intermediaries, managed care plans, the Federal Bureau of Investigation, the Internal Revenue Service, Medicare Fiscal Intermediaries, Health Care Financing Administration, Office of the Inspector General, Medicaid, and licensing programs in other states. For more information or access to records containing your personal information maintained by this agency, contact the Chief, Payment Systems Division, Sacramento, CA, (916) 323-1945.

INSTRUCTIONS FOR COMPLETION OF THE SUPPLEMENTAL APPLICATION

DO NOT USE correction tape, white out, etc.; highlighter pen or ink of a similar type on this form.

This form is a supplemental application for changes to the provider master file. Applicants and providers may also need to provide additional information and documentation. Applicants or providers may be subject to an on-site inspection prior to enrollment.

Omission of any required information or documentation on this form or the failure to sign any of these documents may result in any of the denial actions identified in Title 22, California Code of Regulations, Section 51000.50.

Enter your Medi-Cal provider number in the space provided.

Enter the date you are completing the application.

Provider Type: Enter your provider type in one of the boxes provided.

Action Requested: Check the applicable action you would like made to the provider master file.

Please complete only those boxes necessary to provide the information you are adding, changing, or deleting or to complete the action requested. Be sure to complete boxes 34–39; complete number 40, if applicable.

General Information

1. "Legal provider name" means the name listed with the Internal Revenue Service (IRS).
2. "Business name" means the name of the applicant or provider if different from that listed in number 1. If this is a fictitious business name, provide the Fictitious Business Name Statement or Fictitious Name Permit number and effective date. Attach a legible copy of the recorded/stamped Fictitious Business Name Statement or Fictitious Name Permit to the application.
3. "Business telephone number" means the primary business telephone number used at the business address. A beeper number, answering service, pager, facsimile machine, biller or billing service, or answering machine shall not be used as the primary business telephone.
4. "Business address" means the actual business location including the street name and number, room or suite number or letter, city, county, state, and nine-digit ZIP code. A post office box or commercial box is not acceptable. A provider of incontinence medical supplies or a pharmacy may not make a business address change on this form. Please see California Code of Regulations, Section 51000.30(e).
5. "Pay to address" means the address to which the applicant or provider wishes to receive payment. The "pay to address" should include, as applicable, the post office box number, street number and name, room or suite number or letter, city, state, and nine-digit ZIP code.
6. "Mailing address" is where the applicant or provider wishes to receive general Medi-Cal correspondence. General Medi-Cal correspondence includes bulletin updates and Provider Manual updates.
7. Enter the FEIN issued by the IRS under the name of the applicant or provider. Attach a legible copy of the IRS Form 941, Form 8109-C, Form 147-C, Form SS-4 (Confirmation Notification), or form 2363.
8. If the business is a sole proprietorship not using a Federal Employer Identification Number (FEIN), provide the social security number or Individual Taxpayer Identification Number (ITIN) of the sole proprietor. Attach a legible copy of the ITIN verification, if applicable.
9. Insert the Clinical Laboratory Improvement Amendment (CLIA) number. Attach a legible copy of the CLIA Certificate.
10. Insert the State Laboratory License/Registration number. Attach a legible copy to the application. If not applicable, write "N/A."
11. Insert the Medicare billing number.
12. Insert the Seller's Permit number issued by the State Board of Equalization. Attach a legible copy of the Seller's Permit.
13. Insert any local business license numbers or permits for any city or county or city and county where you conduct your business activities and attach legible copies to the application.
14. If a change of ownership less than 50 percent, list the new ownership information in this space and submit a new Disclosure Statement with an Attachment A for all new ownership interests.

15. List the name and applicable information of the provider being deleted.

16. Check the appropriate boxes and complete all requested information in this question.

17. Enter the change in the business activity you are adding and the licensing information, if applicable. Attach legible copies of any licenses, certificates or permits required. If you have questions regarding the Bureau of Home Furnishings license, please call the Bureau at (916) 574-0280 or the Board of Pharmacy license, please call the Board at (916) 445-5014. If deleting incontinence medical supplies, check the box.

18. Enter all requested information.

19. "Hours of Operation" means the business days and hours the provider is available for service to Medi-Cal beneficiaries.

20. "Geographic Area(s) Served" means those areas which the provider will be transporting Medi-Cal beneficiaries. Attach a copy of the city/county business license/permit with the application. If the city/county does not require a license/permit, you must attach a letter from that city/county with the application which states the city/county does not require a license/permit. It is the applicant's or provider's responsibility to verify with the city/county in which transportation services will be provided for vehicle and driver's permits. If you intend to conduct business in either the City of Los Angeles or the City of San Diego, you must apply for their vehicle and driver's permits. For more information, contact either the City of Los Angeles Department of Transportation or the San Diego Metropolitan Transit Development Board.

21. Enter full legal name of driver or pilot. "Driver's or Pilot's License number" means the number issued by the California Department of Motor Vehicles on the California Driver's License or the number issued by the Federal Aviation Administration on the pilot's license of the individual listed. Attach a legible copy of the license for each driver or pilot with the application. Enter all additional requested information. Attach a legible copy of the DL-51 to the application.

22. Insert the first, middle, and last name of the pharmacist-in-charge at the business location.

23. Provide the social security number of the pharmacist-in-charge. (Optional—See Privacy Statement on page 6.)

24. Insert the license number of the pharmacist-in-charge.

25. Provide the driver's license or state-issued identification number and state of issuance of the pharmacist-in-charge. Attach a legible copy of the driver's license or state-issued identification card to this application.

26–31. Answer all questions as they pertain to the pharmacist-in-charge. If any answers are checked yes, list all details to include license number, dates, licensing agency, Medi-Cal provider information and numbers, etc., in number 32.

32. Provide all details to any yes answers for numbers 26–31.

33. Check the appropriate boxes and complete all requested information in this question.

34. "Printed name of individual signing the application" means the first, middle, and last name of any individual acting on behalf of and with the authority to legally bind the applicant or provider as the sole proprietor, partner, corporate officer, or government official when applying to the Department for enrollment or continued enrollment as a provider in the Medi-Cal program.

35. Check (✓) the gender of the individual named in number 34.

36. Provide the driver's license or state-issued identification number and state of issuance of the individual listed in number 34. Attach a legible copy to the application. The driver's license or state-issued identification number shall be issued within the 50 United States or the District of Columbia.

37. Enter the date of birth of the individual named in number 34.

38. Provide the social security number of the individual named in number 34. Provision of the social security number is optional (see Privacy Statement on page 6).

39. An original signature of the individual listed in number 34 is required. Also provide the title of the person signing the application. Include the city, state, and the date where and when the application was signed.

40. Applicants and providers licensed pursuant to Division 2 (commencing with Section 500) of the Business and Professions Code, the Osteopathic Initiative Act, or the Chiropractic Initiative Act DO NOT have to have this form notarized. If it must be notarized, the Certificate of Acknowledgement signed by the Notary Public must be in the form specified in Section 1189 of the Civil Code.

✓ Remember to attach a legible copy of the following, if applicable:

- ❒ Fictitious Business Name Statement or Fictitious Name Permit
- ❒ FEIN or ITIN verification
- ❒ CLIA Certificate
- ❒ State Laboratory License/Registration
- ❒ Seller's Permit
- ❒ License, permit, or certificate
- ❒ Licenses associated with business activities:
  - ❒ Bureau of Home Furnishings and Thermal Insulation License
- ❒ Furniture and Bedding license
- ❒ Furniture License
- ❒ Bedding License
  - ❒ Medical Device Retailer Certificate
  - ❒ Medical Device Retailer Exemptee Certificate
  - ❒ Other licenses, certificates, permits, etc.
- ❒ Pharmacist-in-Charge License
- ❒ Pharmacist-in-charge driver's license or identification card
- ❒ CHP certificate(s)
- ❒ DMV vehicle registration
- ❒ Proof of full coverage commercial insurance for each vehicle (vehicle identification number ***MUST*** be present on the policy)
- ❒ Brake and lamp certificate
- ❒ FAA certificate
- ❒ FAA pilot's license for each new pilot
- ❒ Certificates for first aid and CPR for each new driver
- ❒ Driver's license for each new driver
- ❒ DMV DL-51 form signed by a physician for each new driver
- ❒ Standard pre-employment drug and alcohol tests lab results for each new driver
- ❒ DMV driving history printout for each new driver
- ❒ Driver's license or identification card of person completing application